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IN THE

Supreme Court of the United States

OCTOBER TERM, 1976

No. 76-811

THE REGENTS OF THE UNIVERSITY OF CALIFORNIA,
Petitioner,

v.

ALLAN BAKKE, *Respondent.*

On Writ of Certiorari to the Supreme Court of California

BRIEF ON BEHALF OF THE AMERICAN MEDICAL STUDENT ASSOCIATION AS AMICUS CURIAE

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BRIEF ON BEHALF OF THE AMERICAN MEDICAL STUDENT ASSOCIATION AS AMICUS CURIAE

On Writ of Certiorari to the Supreme Court of California

This brief *amicus curiae*, in support of the position of The Regents of the University of California, is filed by the American Medical Student Association with the consent of the parties, as provided for in Rule 42 of the Rules of this Court.

INTEREST OF THE AMICUS CURIAE

The American Medical Student Association, founded in 1950, is a nonprofit organization committed to the

improvement of health care and health care delivery to all people. The Association has a membership of over 20,000 medical students, with local chapters at 121 of the nation's 125 medical schools. The Association is dedicated to promoting the improvement of health sciences education, developing sensitivities within its membership to the social, moral, and ethical responsibilities of physicians, and facilitating the understanding and improvement of health problems which face all segments of the population.

The resolution of the issues on appeal in *The Regents of the University of California* v. *Bakke,* insofar as such resolution may threaten the existence of alternative admissions programs in medical schools, is a matter of concern to the Association and its membership. The Association is aware of the significant underrepresentation of racial minorities in medical schools throughout the nation. Its membership recognizes that such underrepresentation contributes to inferior medical care delivery in minority communities. It is our belief that alternative admissions programs, like that at the U.C. Davis School of Medicine, are important and necessary if there is ever to be a remedy to inadequate minority medical care.

I. THE INCREASED ADMISSION OF MINORITY STUDENTS SERVES MULTIPLE SOCIETAL NEEDS.

A. The Shortage of Physicians Serving Minority Communities with Low Indices of Health Can Be Ameliorated by the Admission of Minority Students Who Will Return to Practice in Underserved Minority Communities

The health care needs of minority Americans are not adequately addressed. From birth until death, minorities are not afforded the quality of health and

life of white Americans. In 1968 the maternal mortality rate was three times higher for blacks, for instance, than for whites: .6 per 100,000 live births vs. .2 per 100,000 live births (U.S. Department of Commerce and labor, *The Social and Economic Status of Negroes in the United States*, 1970, SPECIAL STUDIES, BUREAU OF THE CENSUS). And although the infant mortality rate is 19.2 per 100,000 for whites, it is 34.5 per 100,000 for non-whites (W. Darity, *Crucial Health and Social Problems in the Black Community*, JOURNAL OF BLACK HEALTH PERSPECTIVES, June/July, 1974). A white American may make at least one more physician visit per year than a non-white, but overall bed disability and work-loss from ill-health are greater in the non-white population (National Center for Health Statistics, U.S. Department of H.E.W., *Differentials in Health Characteristics by Color, United States,* July, 1965-67). Finally, the life-expectancy of non-whites is 65.2 years, for whites it is 6.7 years longer (W. Darity, *Crucial Health and Social Problems in the Black Community*, JOURNAL OF BLACK HEALTH PERSPECTIVES, June/July, 1974). Mortality statistics such as these present only a glimpse of minority health status. The finer qualities of health and life that are brought about by environmental, social, educational and psychological determinants as well as the level of such factors as employment and nutrition, are, within minority groups, far below optimum.

That minority physicians are uniquely equipped to address the health care needs of fellow minorities is not a fact that lends itself to empirical observation. It is, however, a clear fact for those who are, or have delivered health care to, minority patients. (Appendix pp. 8a-9a *infra*).

In the United States there is 1 physician for every 649 people. However, there is only one black physician for every 4,298 black Americans (T. Thompson, *Curbing The Black Physician Manpower Shortage,* JOURNAL OF MEDICAL EDUCATION, 49(10): 944, Oct., 1974). It has been estimated that there is only one Chicano physician for every 20,000 persons within the Chicano community (H. Herrera, *Chicano Health Professionals,* AGENDA, Winter, 1974). The inequity of these proportions, and of similar statistics for other minorities in medicine, was initially addressed by medical educators in 1970 (B. W. Nelson, *et al., Expanding Educational Opportunities in Medicine for Blacks and Other Minority Students,* JOURNAL OF MEDICAL EDUCATION, 45:731, 1970).

A program aimed at reaching a minimum 12% minority student matriculation in U.S. medical schools by 1975 was instituted in 1970. (A. Thomas, *Project '75: A Program to Increase the Number of Minority Medical Students in U.S. Medical Schools,* JOURNAL OF THE AMERICAN MEDICAL ASSOCIATION, 218(12): 1816, Dec., 1971). That goal, as is well known, was never reached. Only 2.8% and 0.2% of the total medical school enrollment in 1969-70 was black and Mexican-American, respectively (Association of American Medical Colleges, *Medical School Admissions Requirements, U.S.A. and Canada,* Chapter Six: INFORMATION FOR MINORITY FOR MINORITY GROUP STUDENTS, Washington, D.C., 1975). After initially increasing in the early seventies, these figures have leveled off to 6.1% and 1.4% for the 1976-77 school year (Association of American Medical Colleges, U.S. Medical School Enrollments, 1972-73 Through 1976-77, Washington, D.C., Nov., 1976). Regardless of this progress, at the present time there is

not a sufficient number of minority physicians to serve minority communities, and the number of minority medical students now enrolled in medical schools will be insufficient to affect this shortage upon their graduation.

No substantial data have been available, until now, to show that minority health professional students are actually returning to their home communities, or similar communities. Amicus, in Appendix pp. 5a-7a, *infra,* provides evidence which indicates that minorities do return to practice in minority communities in significant numbers.

B. Alternative Admissions Procedures, Such As That Used At The U. C. Davis School Of Medicine, Are Consistent With The Congressional Intent To Facilitate And Increase Minority Enrollment

The Comprehensive Health Manpower Training Act of 1971, (P.L. 92-157) provided for Federal financial assistance to establish programs that "will enhance and facilitate the enrollment, pursuit, and completion of study by individuals" in health professions schools "who due to socioeconomic factors are financially or otherwise disadvantaged" (42 U.S.C. 295f-4). That minority individuals were included in the Congressional intent of this provision has been reconfirmed many times. Most recently, a Senate report stated the purpose of this old amendment as "... to establish programs to facilitate the enrollment, pursuit, and completion of studies of minority students" in health professions schools (Senate Report 94-887, p. 16).

The most recent health manpower legislation, the Health Professions Educational Assistance Act of 1976 (P.L. 94-484), included a provision for "Educational Assistance To Individuals From Disadvantaged Backgrounds". The Act authorizes the Secretary of the Department of Health, Education, and Welfare to make grants to health or educational entities to meet the cost of:

> "(A) identifying, recruiting, and selecting individuals from disadvantaged backgrounds, as so determined, for education and training in a health profession,
>
> (B) facilitating the entry of such individuals into such a school . . ." (42 U.S.C. 295g-7(a)(2))

The Senate Report on this legislation spelled out the intent regarding such assistance:

> "Minority and low income students historically have been underrepresented in health professions schools.
>
> Despite substantial improvements, in the Committee's view, the racial and socio-economic composition of health profession students is still in need of better balance if equality of access to a health profession career regardless of family income or background is to be assured." (Senate Report No. 94-887, p. 226)

The provision was amended to its present form on the floor of the Senate (Congressional Record, S 11302, July 1, 1976). A definitive clarification of the intent to include minority students as "individuals from disadvantaged backgrounds" can be found in a colloquy between Senator Mathias and Senator Kennedy:

Mr. KENNEDY: "Basically it is a provision that was put in the bill in 1971 in terms of assistance to the disadvantaged. We have strengthened it with the Montoya-Tunney amendment by expanding the authorization, to some extent. It has been a good program. It is the kind that medical schools ought to be encouraged to participate in.

Mr. MATHIAS: "Since 1971, enrollments of minority students in medical schools have leveled off, and for the 1975-76 academic year, new admissions of minority students has actually decreased. Thus the need for increasing Federal support for efforts to increase minority enrollment.

Mr. KENNEDY: "I move favorable consideration of the amendment.

The PRESIDING OFFICER: "The question is on agreeing to the amendment of the Senator from Maryland.

"The amendment was agreed to."

Millions of taxpayers' dollars have been appropriated annually for facilitating the entry and retention of minority students in health professions schools. Most recently, the House Committee on Appropriations, Subcommittee on Labor, Health, Education, and Welfare approved a $14.5 million appropriation for such educational assistance for the fiscal year 1978 (House Report No. 95-381, p. 55). The counterpart Subcommittee in the Senate recommended an equal appropriation (Committee on Appropriations, Subcommittee on Labor, Health, Education, and Welfare, open "mark-up" session, May 25, 1977).

The Congressional intent regarding the admission of minorities into medical school is clear. The existence of alternative admissions policies such as that employed at the U. C. Davis School of Medicine is in

keeping with the position of the Congress of the United States.

C. A Diverse Student Population Provides Benefits To Students, Educators, And The Community

Regardless of the cultural, socio-economic or educational background of the physicians who will serve minority communities, the presence of minority students in medical schools will increase the future practitioner's awareness and sensitivity to the medical needs of minorities and early on inculcate a responsiveness to the unique demands of cross-cultural medical practice. Such a sensitivity in all physicians is a necessity, for until the percentage of minority physicians approaches parity with the percentage of minority population, the pursuit of national health goals will require that non-minority physicians render health care services to the underserved minority population.

The diversification of a student body affords the medical student an experiential exposure to the differing perceptions, behaviors, reactions and aspirations of peers from other backgrounds. This stimulation can be ideally provided at a time when, due to the student's immersion in an intensive educational period, he or she is especially receptive to new experiences. As any medical student knows, the principle assets of medical education are patients, teachers, and fellow students.

The professional medical educator also benefits from the stimulation and interchange created by the presence of non-majority students. Educators gain by the broadening of perspectives and the development of sensitivities and interpersonal skills which are possible through a diverse student enrollment.

Medical faculties have long sought a variety of applicants. For an admissions committee to give more weight to a student coming from a certain geographic locale or possessing a unique athletic or artistic ability or work experience, or expressing the desire to enter a particular medical specialty, is in no way unusual. What is unusual is that educators have only recently recognized that growing up as a minority in America is an experience of encounters, reactions and accomplishments which merits no less consideration than a 9.5 second 100 yard dash, a 3.9 grade point average, or the desire to practice thoracic surgery. That the consideration of minority status has not occurred earlier is in itself an indication that the majority has only recently realized the benefit to all of encouraging a minority to realize his or her own inherent potential.

In Appendix p. 10a, *infra*, the Association presents for the Court's perusal a representative student's perspective on this issue.

D. Minority Youths Must Have Role Models If They Are To Aspire to Serve Society as Health Professionals.

Without the availability and visibility of sufficient numbers of minority role models, it is not now, nor will it be in the future, possible for minority youths to model and attain the attributes which are needed to enter the medical profession as it exists today.

An adequate number of such role models may also serve to create a needed diversity in the leadership of national health endeavors. Whether such leadership deals with the delivery of medical services or with policy formation, minority youths could observe men and women from similar backgrounds in positions of responsibility and leadership.

The medical needs of this country's minorities can not wait twenty or fifty years for an environmental and educational opportunity system which would not discriminate in favor of the majority. The acceptance of minority students in medical schools, and their subsequent emergence as role models—as well as practitioners and leaders—shortens the intolerable wait for true equal opportunity for health care services, and for a health professional education.

The Association wishes to share with this Court the letter in Appendix pp. 11a-12a, *infra,* which we believe demonstrates this argument's validity in an uncontestable manner.

II. THE MEDICAL COLLEGE ADMISSIONS TEST AND THE UNDERGRADUATE GRADE POINT AVERAGE ARE INAPPROPRIATE INSTRUMENTS FOR ADMISSION TO MEDICAL SCHOOL

A. The MCAT And The UGPA Are Not Valid Selection Instruments Because They Do Not Predict Either Success In Medical School Or Success As A Physician.

Any argument which is grounded in the assertion that a medical school should not accept a "less qualified" applicant assumes that a valid test exists by which one can determine who is "more qualified" or "less qualified." Traditionally the Medical College Admissions Test (MCAT) and the Undergraduate Grade Point Average (UGPA) have been used to judge qualifications. The Association contends, however, that neither is valid as a medical school qualification test.

The MCAT was originally developed to reduce attrition in medical schools; it was never designed to be used as a selection mechanism for admission (Erdmann, *Separating the Wheat from the Chaff: Revision of the M.C.A.T.,* JOURNAL OF MED. 47(9): 747, (Sept. 1972)).

Numerous studies have been performed comparing a student's MCAT and UGPA scores with later clinical performance. In a 1963 study at the University of California Medical School at San Francisco, the median correlation between UGPA and four-year medical school GPA was only +.20. Thus only 4% of the variation in achievement can be accounted for by differences in undergraduate grades. The correlation between MCAT science scores and medical school GPAs were .28 for the first year, .10 for the second year, .01 for the third year, and .00 for the fourth year. The correlation with MCAT verbal scores was even more disparaging with .14 for the first year, .08 for the second, —.05 for the third, and —.07 for the fourth (Gough, H. G. *et al., Admissions Procedures as Forecasters of Performance in Medical Training,* JOURNAL OF MEDICAL EDUCATION, 38(12): 983, Dec. 1963).

In a 1962 study comparing UGPA and MCAT scores with the performance of physicians in their internship year, premedical grades bore practically no relationship to an intern's performance, while MCAT scores actually had a slightly *negative* correlation to internship performance (Richards, J. M. *et al., The Prediction of Medical Intern Performance,* JOURNAL OF APPLIED PSYCHOLOGY, 46(2): 142, 1962). In a study comparing MCAT scores of randomly selected physicians in the Public Health Service with supervisor ratings in various clinical skills, clinical performance was *negatively* correlated with the MCAT sores (Howell, M. S., *et al., The Medical College Admissions Test as*

Related to Achievement, JOURNAL OF MEDICAL EDUCATION 42: 1037 (1967)). Dr. Price, Dean Emeritus of the University of Utah College of Medicine has commented:

> "This is a somewhat shocking finding for a medical educator. . . . It is true that a strong suspicion that grades have been weighed too heavily in predicting performance in medical school and after graduation from medical school is what led to the initiation of this whole study in the first instance, but to have that suspicion so forcefully corroborated has led me to question the adequacy of some of our traditional admissions policies." (Price, P. B., *et. al., Measurement of Physician Performance;* Discussion, JOURNAL OF MEDICAL EDUCATION, 39(2): 203-211, 1962)

Even the Association of American Medical Colleges (AAMC), which administers the MCAT, has recognized the invalidity of the MCAT as a criterion for admission. The entire format has been revised for the 1977 year, in response to the numerous complaints and its acknowledged severe limitations. The AAMC has stated:

> . . . there is general agreement that the current MCAT is inadequate to the information needs of medical schools, applicants, and their undergraduate advisors. . . . It is primarily a test of academic aptitude for scientific training, and there is a growing recognition of a need to tie admissions decisions more explicitly to a broader range of those characteristics important to the future performance of physicians . . . (Association of American Medical Colleges, MCAAP Information Series, No. 1, Association of American Medical Colleges, 1974).

A recent study looked at medical students who received honors during their clinical and pre-clinical years. Only one-half of those who received basic science honors subsequently received clinical honors. Rhoads, in referring to the basic science honor students who did not earn clinical honors, stated, ". . . their performance with patients was subtly disturbing because they appeared to be uninterested in patients as people." (Rhoads, John M., *et al., Motivation, Medical School Admissions and Student Performance,* JOURNAL OF MEDICAL EDUCATION 49(12); 1119, July, 1967). Furthermore, almost three-fourths of the students who received clinical honors had not obtained basic science honors and had UGPA which were below (3.3 compared with 3.5) that of their class in general.

Despite their generally lower traditional admissions credentials, over ninety per cent of minority medical students have performed competently and earned their M.D. degrees (Johnson, *Retention by Sex and Race of 1968-1972 U.S. Medical School Entrants,* JOURNAL OF MED. ED. 50: 952, 1975). Thus, minority students have proven retrospectively that they were qualified to study medicine.

The conclusion to be drawn from this data is that the traditional tests of qualification do not predict who is in fact "best qualified" to succeed in medical school and as a physician.

B. The Use Of The MCAT And UGPA, While Not Insuring That The Best Qualified Are Admitted To Medical School, Does Insure That Minority Students Are Not Admitted.

The experience of the Davis Medical School prior to the institution of its special admissions procedure aptly demonstrates what happens when the MCAT and UGPA are utilized as the primary criteria for determining admissions.

Although blacks and Chicanos represent 8% and 17.5%, respectively, of California's population, Davis Medical School in 1968 admitted no blacks or Chicanos. In 1969, only two blacks and one Chicano were admitted. From 1970 through 1974, 39 Chicanos, 27 blacks and 1 Native-American had entered the medical school. Of those, 33 Chicanos, 26 blacks, and the one Native-American were admitted through the special admissions program. Thus, in 1969, before the special admissions program was initiated, Davis admitted only 3 minority students out of 200 entering medical students, or only 1.5% of the student body in a state in which the minority population was over 20%. Between 1970 and 1974, only 7 of the 67 minority students who entered Davis Medical School were processed outside of the Special Admissions program. Thus, even in those years there would have been only 7 minority students of 500 students *but* for the special admissions program.

Dr. Lowrey, Dean of Admissions at Davis, openly admitted that if it were not for the special admissions program, intolerable underrepresentation would continue today:

> My experience as chairman of the admissions committee has convinced me that there would be few, if any, black students and few Mexican-Americans, Indians or Orientals from disadvantaged backgrounds in the Davis Medical School, or any other medical school, if special admissions programs and similar programs in other schools do not exist." (C.T. 67-69).

Other admissions committee members, at Davis and elsewhere, point out the existence of "discretionary" admissions procedures which reflect negatively on the validity of the admissions process in general (Appendix pp. 1a-4a).

CONCLUSION

For the foregoing reasons, the American Medical Student Association respectfully submits that the judgment of the California Supreme Court should be reversed.

Respectfully submitted,

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June 7, 1977

APPENDIX

APPENDIX

June 4, 1977

Kevin Kunz
Affirmative Action Task Force
American Medical Student Association

Dear Kevin:

I am a black physician serving as Assistant Professor of Obstretics-Gynecology and Community Medicine at the Georgetown School of Medicine. As a member of the admissions and retention committees at Georgetown over the past four years, I have had the opportunity to gain significant insight into admissions and retention policies both at my own institution and at other medical schools. It is clear that many medical schools have had a long history of unabashedly employing a double standard for admitting students: the normal standard under which the majority of students are accepted and then the other infrequently mentioned one reserved for the "discretionary" admission of sons and daughters of alumni, faculty, wealthy contributors, and politicians.

The medical schools defend this discretionary admission of white students on the basis that consideration of qualities other than GPA and MCAT scores justify such admissions. Yet, while medical schools weakly voice the same arguments on behalf of minority student admissions, they have adopted policies which make performance on standardized tests even more critical for admission and retention. This greater emphasis on objective test performance discriminates against those who have not been fortunate enough to have had the opportunity to developed competitive skills early in their educational careers. It is for this reason, coupled with the fact that such skills take years

to cultivate, that we as medical educators and policy-makers must continue our support of Affirmative action programs.

Sincerely yours,

/s/ Arthur Hoyte, M.D.

June 3, 1977

Kevin Kunz
Affirmative Action Task Force
American Medical Student Association

Dear Kevin:

I have been a member of the Task Force Admissions Committee at the U.C. Davis School of Medicine for two years, and in my experience no one has been admitted through this committee who did not satisfy the academic requirements. On the other hand, at least one non-minority student was admitted with academic standards lower than those "required" in the *U.C. Davis School of Medicine Bulletin.* Thus, if anyone is receiving preferential treatment, it is the rich and politically influential people that were admitted "through the back door" (see *The New Physician,* Nov. 1976).

As a minority student I am already contributing to the improvement of health care delivery to my community by actively participating in a Chicano clinic in Sacramento, as a Director and medical worker for the past two years. It is clear to me that my community needs doctors who not only understand our language, but who also have a deep understanding of our culture.

As a third year student, I will be taking electives this summer working in a county hospital in a rural area, and in a farm worker clinic, also in a rural area. I am convinced that most of the other minority students from Davis share my desire to go back to their respective communities where doctors are sorely needed. If our alternative admissions program is discontinued, our communities will loose even this token number of future physicians, and their needs will become more exaggerated.

I hope that the truth will be as clearly evident to the Justices of the Supreme Court, as it is to those of us who will be directly affected by whatever decision they make.

/s/ Antonio Velasco
Third Year Student
U.C. Davis Medical School

June 2, 1977

Kevin Kunz
Affirmative Action Task Force
American Medical Student Association

Dear Kevin:

My name is Luis Gonzales. I went to dental school at the University of California, San Francisco, graduating in 1974. I am currently on the faculty of U.C.S.F. Dental School and am co-director of the recruitment program for minority and disadvantaged persons at the school. I have sat on the admissions committee for three years.

You have asked me to write a letter concerning whether or not minority students admitted to health professional schools, once they are trained, return to practice in minority communities. I will present data below showing that the overwhelming majority of minority dental school graduates do in fact end up practicing in predominantly minority communities.

There is very little, if any, published data relating to this question. A major reason for the paucity of data is the paucity of minority students who were admitted to health professional training until recently, that is, there have been very few minority health professional students and practitioners to study. For example, at my own school there was not a single Black graduate between 1946 and 1972! The only public dental school in California (during almost all of that period) did not admit a single Black dentist in 26 years although Blacks comprise approximately 8% of the state's population. This lack of minority health professional graduates is also the reason that dental graduates, instead of medical graduates, are asked to answer the above question. Significant numbers of minority students were first admitted to health professional school in California in 1969. Medical students go to medical school for four years and then on to internship and residency pro-

grams, which generally last three or more years. For medical persons there is thus a seven year lag period between being admitted to medical school and being fully trained and able to make their decisions as to practice location. This first significant number of minority physicians completed their training in California only this past June of 1976. Many are in temporary situations or in transition during their first year as fully trained practitioners, and data on them would, therefore, be of questionable reliability. Dental students, on the other hand, complete four years of dental school, and go directly into practice. Significant numbers of minority students were also first admitted to dental schools in California in 1969 and began practice in 1973.

My office has looked at the practice location of minority graduates of U.C.S.F. Dental School admitted since 1969. Our studies show that of the 82 minority graduates between 1973 and 1976, 14 are in the military or in post-graduate training. Of the remainder, *82* percent are practicing in predominantly minority, dental manpower shortage areas.

Further, the Office of Health Professions Development of the California State Department of Health recently completed a survey of minority graduates of all the dental schools in California. They found that of those who are in practice in California, 85 percent provide services predominantly to minorities (over 50 percent of their patients were minority persons) (Dental Graduate Survey, Office of Health Professions Development, California State Department of Health, May 1977, to be published)

Thus, from the above data, it is quite clear that the overwhelming majority of minority dental school graduates from California schools do, of their own volition, practice in predominantly minority areas for minority persons. This positive outcome of minority admissions programs has been achieved despite the facts that those are generally poor areas, that many minority dental graduates com-

plete their training with $10,000 to $40,000 in loans which they must repay, and that setting up a dental practice requires $20,000 to $50,000 in capital investment for equipment.

I believe that this overwhelming success rate for minority dental school graduates will be shown to be true for other minority health professional graduates, if not even greater for physicians. Only a small percentage of the population has health insurance which covers dental care, while even in poor communities a significant percentage of persons have health insurance which covers at least some portion of medical care. Too, the capital investment required to start medical practice is much less than that required to start dental practice.

I would like to end this letter with a statement and a question. There is considerable evidence that affluent, mainly suburban areas of the United States have in fact an oversupply of health professional manpower, often resulting in surgery, procedures, and laboratory tests of questionable utility to patients in these areas. On the other hand, minority areas generally have an extreme shortage of health professionals with consequent higher rates of preventable or treatable deaths, morbidity, and disability. Is it more in the national interest to accept an Anglo student into health professional training who is very likely to practice in an affluent, health professional surplus area or to accept a minority student who will have a very high likelihood of practicing in a minority, health professional shortage area where his or her services are desperately needed?

Sincerely yours,

/s/ Luis Gonzales, D.D.S.
School of Dentistry
University of California
San Francisco, California

May 28, 1977

Kevin Kunz
Affirmative Action Task Force
American Medical Student Association

Dear Kevin:

My name is Robert Montoya. I graduated from the University of Southern California School of Medicine in 1971 and from the U.C.L.A. School of Public Health in 1974. I am presently employed by the California Department of Health. In this letter, I would like to primarily draw on my own experiences as a Chicano physician to point out the skills that persons from minority cultural and linguistic backgrounds bring with them into health professional training and practice.

As a student at USC, I cared for a 35 year old Mexicana who had symptomatic aortic stenosis. Aortic stenosis is a condition with which people can do quite well until they become symptomatic, then 95% die within one year if not surgically corrected. Thus, this woman was in desperate need of surgery to correct her condition. Residents, interns, and staff physicians, through interpreters, attempted to convince her of the necessity for the operation, but she had refused. After she had been on the ward for one week, somebody got the idea of my speaking with her. At that time I and one of my classmates were the only Mexicano medical students, interns, residents, or physicians in the hospital. I spent about an hour talking with this woman and found that despite multiple "explanations" through an interpreter, she knew very little about the operation and her need for it. She was planning on getting out of the hospital as soon as she felt well and returning to Mexico where she would seek attention from traditional healers. I explained the operation to her, her need for it, and what she could expect during her recovery. She then went to surgery, and I presume she is still alive today.

Another case I would relate is that of a diabetic Chicano whom I met while interning. This woman had poorly controlled diabetes. She had numerous admissions to the hospital to attempt to control it, but without much success. A fellow intern asked me to speak with her. I went over her medical and dietary history carefully and spoke with her. Basically, I found what was the major problem in controlling her diabetes—she regularly ate sweetbread. Other physicians, during her previous and present admissions, noted in her dietary history that she ate sweetbread. They had thought that she was referring to pancreas, and gave it little significance. She was fully fluent in English and Spanish and what she had done when giving her dietary history was to translate directly *pan dulce* to sweetbread. We spoke primarily in English, but with me she used the term *pan dulce* (there is no exact equivalent food or term in Anglo culture.) I immediately recognized the significance of her pan dulce intake. I kept in touch with her after discharge and she did quite well by drastically cutting down on her pan dulce intake. In essence, just this simple discovery greatly improved the control of her diabetes.

The point of all of this is that, based on my own experiences as a physician, the knowledge, skills, and abilities that I possessed prior to being admitted to medical school have made me a more effective and capable physician with a large proportion of my patients. Most of these skills can not be learned from books or acquired even during an extensive total immersion in a culture. These skills generally are covariables with an applicant's race. I thus believe race, and its cultural and linguistic aspects and the inherent abilities of its members, are very valid criteria for admission to health professional schools.

Sincerely yours,

/s/ Robert Montoya, M.D., M.P.H.

Kevin Kunz
Affirmative Action Task Force
American Medical Student Association

May 30, 1977

Dear Kevin:

My class at the University of Arizona School of Medicine was composed of 90 students, of which 5 were Chicano, one was a black, and one was a Native-American. Through my interactions with these seven minority students, my perception of the health needs of underserved populations, and of the unique problems which impact on the health of these populations, was greatly enhanced. One of my first revelations was the completely different perspective on life, and on attitudes toward health care, that exist in different cultural groups. These ethnic attitudes can only be completely understood by someone from the same background; however, through intense and continual contact with minority students, white medical students can develop a deeper understanding and sensitivity to the unique problems of minority patients. Such a personal exposure for white students to the attitudes, beliefs, and health conditions of different racial groups is essential to develop the needed responsiveness to the personal and community health concerns of minorities.

My experience with these minority students has furthermore enabled me to reevaluate and discard many of my own stereotypes. By getting to know each of these fellow students as a person, I have developed an appreciation for the necessity of addressing my patients, both minority and non-minority, as unique persons, rather than as stereotyped "kidney disease" patients or "terminal cancer" patients.

For these reasons, I realize medical education can not ignore the importance of enrolling adequate numbers of minorities.

Sincerely yours,

/s/ Doug Outcalt
AMSA National President

May 31, 1977

Kevin Kunz
Affirmative Action Task Force
American Medical Student Association

Dear Kevin:

I am a black woman and a second year student at Harvard Medical School. I attended Spelman College, a black women's college, in Atlanta, Georgia. My interests in medicine as a career were solidified during the two summers I spent at the United Negro College Fund sponsored Pre-Med Program at Fisk University. If you have not surmised already, I emerge from a black academic and social background. With the exception of the 8th and 9th grade, and medical school, I have been in black educational institutions throughout my training.

To speak to the issue of role models, I'd like to draw from my personal experiences. I have always known that black people could be physicians—and good physicians—because all of my own physicians from birth to my coming to Harvard have been black, two were black women. While attending the Fisk Pre-Med Program, I had black medical and dental students as counselors, which made the possibility of my assuming the role of medical student even more plausible. These role models helped me attain the self-esteem and self-respect that I needed to confidently pursue a career as a physician. As a result of this exposure, I was uninhibited about my desire to be a physician in regards to whether I as a black woman could do it or not. I knew that it had been done and was being done. The importance of black role models has not stopped with my entering medical school. When I see blacks graduating and listen to those ahead of me tell me that I can make it, I get the stuff I need to keep on going. I know black women who graduated from my undergraduate school as well as

from Harvard Medical School whom I look to for continued reassurance.

I have only recently directly felt the emotional and self-undermining effects of being surrounded by and directly evaluated by a large number of uncaring white people. It is with my present experiences that I am recommitted to the need for affirmative action which will result in black role models to emphasize constantly to black children their potential. I know that my early experiences, and my experiences throughout my training, are unfortunately not the norm for black children and black students. Had my early surroundings and experiences been as theirs, very definitely my potential to become a physician could have been nipped in the bud.

Sincerely yours,

/s/ Deborah Stith